

STRUCTURES DEREK INTERNATIONAL S.A.**Employer's report of injury**

PROJECT NAME:

IRS Service Ctr.**EMPLOYEE INFORMATION**

NAME	(b) (6)	(b) (6)
ADDRESS	(b) (6)	

LOSS INFORMATION

DATE OF LOSS	<u>5 / 27 / 2010</u>
TIME EMPLOYEE BEGAN WORK	<u>7:00 AM</u>
TIME OF LOSS	<u>1:45 PM</u>
DATE EMPLOYER NOTIFIED	<u>5 / 27 / 2010</u>
LAST DAY WORKED	<u>5 / 28 / 2010</u>
DATE RETURNED TO WORK	<u> / / </u>
DATE DISABILITY BEGAN	<u> / / </u>

INJURY / EXPOSURE INFORMATIONNature of Injury and Description:Cut finger requiring 15 stitchesBody part and Description:Left ring fingerCause of Injury and Description:While holding welding lead & traveling with scissor
lift lead got caught under wheel pulling hand down
onto L280 wire feeder pinching and cutting finger

Was the injury / exposure fatal? If yes, date of death?

No

LOSS DETAIL INFORMATION

Describe accident - give sequence of events

While holding welding cable & traveling with scissor
lift cable got caught under wheel pulling hand down
onto LNAS wire feeder pinching & cutting left ring finger

Describe object that directly caused the accident

Welding cable & scissor lift

Describe equipment, materials or chemicals in use at the time

Scissor lift

Describe work process employee was engaged in at time of accident

welding

Describe what employee was doing when injured

Traveling in scissor lift

Were safeguards / safety equipment provided? Were they used?

yes

INITIAL TREATMENT / WITNESS INFORMATION

Initial treatment

Laceration closed with stitches

Injured Name, Address and Telephone

(b) (6)

Witness Name and Telephone:

Any comments

INCIDENT REPORT

Project Number: 1366	Date of Incident: 6/25/12	Project Name and Address: IRS Modernization Project	
Time of Incident: 11:30am	Location of Incident: Penthouse 3	<input type="checkbox"/> Columbia Incident <input checked="" type="checkbox"/> Subcontractor Incident	
INCIDENT TYPE		<input type="checkbox"/> Were photographs taken? NO	
<input type="checkbox"/> Struck Against <input type="checkbox"/> Fall on same level <input type="checkbox"/> Exposure to Extreme Heat or Cold <input type="checkbox"/> Struck By <input type="checkbox"/> Fall to different level <input type="checkbox"/> Physical Agents (Noise, radiation, etc.) <input type="checkbox"/> Caught Between <input type="checkbox"/> Respiratory <input type="checkbox"/> Contact with Electrical Current <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Skin Irritant <input checked="" type="checkbox"/> Other (please describe below):		<input type="checkbox"/> Fire <input type="checkbox"/> Theft/Vandalism <input type="checkbox"/> Vehicle/Equipment <input type="checkbox"/> Near Hit	
Cut to pointer finger on left hand			
INJURY			
Name of Injured: (b) (6)	Occupation: laborer	Employer: A1	Employer Address and Telephone #: (b) (6)
	Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	D.O.B: 9/27/87	Supervisor Name: (b) (6)
Lost Time?: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Fatality?: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
PROPERTY DAMAGE			
Accident Location:		Date Reported:	
Describe Property Damaged / Lost / Stolen:			
Nature of Damage / Loss:		Source / Object Inflicting Damage:	
DESCRIPTION - Describe what happened (who, what, where, when, and how)			
<input type="checkbox"/> Were any sketches made? NO			
(b) (6) was cutting a piece of duct with a grinder. During this process a loose piece of demoed pipe rolled onto the cord of the grinder jerking it out of his hand. As he reacted to the grinder being pulled from his grip he reached to control the grinder from hitting any part of his body. In doing so it came into contact with his finger. Gloves were worn at the time.			
EVALUATION List all causes of accident / loss			
What Were the Job Factors, Unsafe Conditions, or Unsafe Practices That Contributed to the Incident: * 3 stitches needed to close loose demo debris wound *			
Severity Potential: <input type="checkbox"/> Major <input type="checkbox"/> Serious <input checked="" type="checkbox"/> Minor		Reasons for recurrence:	
CORRECTION - Describe Steps Taken to Prevent Future Incidents / Losses			
Make sure demo debris is stable at all times or disposed of immediately.			
Prepared By: Sean Fitzgerald	Sig: (b) (6)	Date: 6/26/12	

INCIDENT REPORT

Project Number: 1366		Date of Incident: 05/27/2010		Project Name and Address: IRS Modernization Project 310 Lowell Street Andover, Ma	
Time of Incident: 1:45pm		Location of Incident: Inside phase 1. Exact location unknown at this time.		<input type="checkbox"/> Columbia Incident <input checked="" type="checkbox"/> Subcontractor Incident	
INCIDENT TYPE				<input type="checkbox"/> Were photographs taken?	
<input type="checkbox"/> Struck Against <input type="checkbox"/> Struck By <input type="checkbox"/> Caught Between <input type="checkbox"/> Sprain/Strain		<input type="checkbox"/> Fall on same level <input type="checkbox"/> Fall to different Level <input type="checkbox"/> Respiratory <input type="checkbox"/> Skin Irritant		<input type="checkbox"/> Exposure to Extreme Heat or Cold <input type="checkbox"/> Physical Agents (Noise, radiation, etc.) <input type="checkbox"/> Contact with Electrical Current <input checked="" type="checkbox"/> Other (please describe below): Cut to the ring finger on the left hand	
<input type="checkbox"/> Fire <input type="checkbox"/> Theft/Vandalism <input type="checkbox"/> Vehicle/Equipment <input type="checkbox"/> Near Hit					
INJURY					
(b) (6)		Occupation: Ironworker		Employer: Structures Derek	
		Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		D.O.B: (b) (6)	
Lost Time?: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Fatality?: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		Employer Address and Telephone #: 185 rue St-Antoine Sainte-Marie, Bce, Qc Canada G6E 4B6 Supervisor Name: (b) (6)	
PROPERTY DAMAGE					
Accident Location:				Date Reported:	
Describe Property Damaged / Lost / Stolen:					
Nature of Damage / Loss:			Source / Object Inflicting Damage:		
DESCRIPTION - Describe what happened (who, what, where, when, and how)					
<input type="checkbox"/> Were any sketches made?					
The following is an account of what happened as described to me by the Structures Derek Foreman (b) (6) indicate (b) (6) cut his finger on a spool of welding wire. It was reported that (b) (6) as traveling in a scissor's lift or lift while holding his welding lead in one hand dragging it along with him. The welding lead got tangled under a wheel of a T the scissor lift and caused (b) (6) hand to slide back into the welding wire spool causing the injury.					
EVALUATION List all causes of accident / loss					
What Were the Job Factors, Unsafe Conditions, or Unsafe Practices That Contributed to the Incident:					
An unsafe practice caused this accident. Had the alleged injured party disconnected the welding lead prior to traveling in the scissor lift the alleged injury would not have occurred. This is a case of operator error.					
Severity Potential: <input type="checkbox"/> Major <input type="checkbox"/> Serious <input checked="" type="checkbox"/> Minor				Reasons for recurrence:	
CORRECTION - Describe Steps Taken to Prevent Future Incidents / Losses					
In future all equipment, cords, etc. should be disconnected prior to moving the scissor lift in a horizontal motion.					
Prepared By: Sean Fitzgerald		Signed: (b) (6)		Date: 06/07/2010	

INCIDENT REPORT

Project Number: 1366	Date of Incident: 3-18-10	Project Name and Address: IRS 310 LOWELL ST ANDOVER	
Time of Incident:	Location of Incident: SECTOR A CANOPY AREA	<input type="checkbox"/> Columbia Incident <input checked="" type="checkbox"/> Subcontractor Incident	
INCIDENT TYPE		<input type="checkbox"/> Were photographs taken?	
<input type="checkbox"/> Struck Against <input type="checkbox"/> Fall on same level <input type="checkbox"/> Exposure to Extreme Heat or Cold <input type="checkbox"/> Struck By <input type="checkbox"/> Fall to Different Level <input type="checkbox"/> Physical Agents (Noise, radiation, etc.) <input type="checkbox"/> Caught Between <input type="checkbox"/> Respiratory <input type="checkbox"/> Contact with Electrical Current <input checked="" type="checkbox"/> Sprain/Strain <input type="checkbox"/> Skin Irritant <input checked="" type="checkbox"/> Other (please describe below):		<input type="checkbox"/> Fire <input type="checkbox"/> Theft/Vandalism <input type="checkbox"/> Vehicle/Equipment <input type="checkbox"/> Near Hit	
INJURY			
Name of Injured: (b) (6)	Occupation: CARPENTER	Employer: DB CONTRACTORS	Employer Address and Telephone #: 290 FOX AVE 417-789-5578 DRAST MA 01824
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	D.O.B:	Supervisor Name: (b) (6)	
Lost Time?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Fatality?: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
PROPERTY DAMAGE			
Accident Location:		Date Reported: 3-18-10	
Describe Property Damaged / Lost / Stolen:			
Nature of Damage / Loss:		Source / Object Inflicting Damage:	
DESCRIPTION - Describe what happened (who, what, where, when and how)			<input type="checkbox"/> Were any sketches made?
<p>While cleaning Ram set NAIL GUN (b) (6) Accidentally discharged the gun.</p> <p>Ram of the gun punctured left hand</p>			
EVALUATION - List all causes of accident / loss			
What Were the Job Factors, Unsafe Conditions, or Unsafe Practices That Contributed to the Incident :			
(b) (6) should have checked to see if shot was in the gun prior to cleaning			
Severity Potential: <input type="checkbox"/> Major <input type="checkbox"/> Serious <input checked="" type="checkbox"/> Minor		Recurrence Potential: <input type="checkbox"/> Likely <input type="checkbox"/> Occasional <input checked="" type="checkbox"/> Unlikely	
Have Similar Accidents / Losses Occurred Before?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Reasons for recurrence:	
CORRECTION - Describe Steps Taken to Prevent Future Incidents / Losses			
Prepared By: (b) (6)		Date: 3-19-10	

FORM 101



The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 101

1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA USE ONLY

Print Form

**EMPLOYER'S FIRST REPORT OF INJURY
OR FATALITY**

THIS FORM MUST BE FILED BY THE EMPLOYER IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.
INSTRUCTIONS AND CODES ON THE REVERSE SIDE - Please Print Legibly or Type - Unreadable forms will be returned.

EMPLOYEE	1. Employee's Name (Last, First, MI): (b) (6)		2. Home Telephone Number:		3. Social Security Number*:		4. Sex: <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
	5. Home Address (No. Street, City, State & Zip Code): (b) (6)				5a. Native Language Code: Other:		6. Marital Status: <input type="checkbox"/> M <input checked="" type="checkbox"/> S	
	8. Date of Hire (mm/dd/yyyy): 07/08/2010		9. Date of Birth (mm/dd/yyyy): (b) (6)		10. Average Weekly Wage: \$ 1,200 <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Actual		12. Federal Tax I.D. Number: 04-3207191	
EMPLOYER	11. Employer's Name: Newton Contracting				14. Employer's Telephone Number: 617-244-9911			
	13. Employer's Address (No., Street, City, State & Zip Code): 69 Howard Street Watertown, MA 02472				15. Industry Code (See Reverse Side):			
	16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR): Meadowbrook Insurance Group				17. W.C. Policy Number: 0672707			
INJURY INFORMATION	18. Self-Insured? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Self-Insurer Number:				19. Business Type: <input checked="" type="checkbox"/> Service <input type="checkbox"/> Wholesale <input type="checkbox"/> Mfg. <input type="checkbox"/> Retail <input type="checkbox"/> Other			
	20. DATE OF INJURY (mm/dd/yyyy): 09/16/2011				20a. Insurer's Case/Claim File No.:			
	21. Was Employee Injured on Employer's Premises? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				22. Location of Injury if not on Employer's Premises: IRS, N. ANDOVER, MA			
	23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):				24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):			
	25. If Employee has Died, Date of Death (mm/dd/yyyy):				26. Source of Injury (Chemicals, Machinery, etc.): Laceration			
	27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved: Pushing generator, which got caught up, while he was pushing it, generator punctured Right Leg, just below knee (Lawrence Memorial Hosp. Received 9 Stitches) 800-540-9191							
	28. Person to Whom Injury was Reported (list position): Steve Mahoney - Foreman				29. Date Reported (mm/dd/yyyy): 09/16/2011		30. Date Reported as work related (mm/dd/yyyy): 09/16/2011	
	31. Injury Code(s) a. 170 to body part		Body Part Code(s) a. 510		32. Witness(es) to Injury - Give Full Name(s), if none state as such: (b) (6)			
	b. to body part		b.					
PREPARER	33. Has Employee Returned to Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				34. Date Employee Returned to Work (mm/dd/yyyy): 09/19/2011			
	35. Employee's Regular Occupation: ROD FEE R				36. Has Employee Returned to Regular Occupation: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	37. PREPARER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE): Suzanne Higgins				38. PREPARER'S Title: Admin. Assistant			
39. PREPARER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE): (b) (6)				40. Date Prepared (mm/dd/yyyy): 09/21/2011		40a. PREPARER'S e-mail address: shiggins@newton-boring.com		

*Disclosure of Social Security Number is required by law. Form 101 - Revised 7/2010 - Reproduced as needed.

THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.

OUR FOREMAN AND EMPLOYEE ARE INSTRUCTED NOT TO FILL OUT ANY ADDITIONAL REPORTS. IF YOU REQUIRE INFORMATION ON ANOTHER FORM PLEASE CONTACT REBECCA KERWICK AT 401-331-2277 EXT. 261 TO AID IN COMPLETION. THANK YOU FOR YOUR COOPERATION.

Accident Reporting and Treatment (ART) Form

Job Location Andover Ma. Job# 526 Date 1/16/13

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T
A

Employee Data:	Name of Employee:	(b) (6)	
Occupation:	<u>Carpenter</u>	Social Security #	(b) (6)
Home Address:	(b) (6)		
Home Phone #	(b) (6)	Other Phone #	<u>SAME</u>

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Accident Data:					
Date of Injury	<u>1/16/2013</u>	Time	<u>2:30</u>	am/pm	<u>(pm)</u>
What was the source of the injury?	<u>Metal Stud</u>	Witnesses? (List)	(b) (6)		
Describe how the injury occurred	<u>Metal Stud fell off Staggering</u>				
What body parts (right or left) are involved?	<u>Left forearm</u>				

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First Aid Data:	Employee	<input checked="" type="checkbox"/>	Did	<input type="checkbox"/>	Did Not Request treatment
What kind of treatment was provided?					
Treatment given by:			Time	a.m./p.m.	
Employee may:	<input type="checkbox"/> Return to Work		<input type="checkbox"/> Needs Additional Treatment		

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Medical Provider Data:	*** please give the yellow copy to the physician *****				
Medical Facility Name			Medical Provider Name		
			Phone Number		
What kind of treatment was provided?					
<input type="checkbox"/> New Injury <input type="checkbox"/> No Injury/Illness found <input type="checkbox"/> Recurrence of existing condition					
Recommendations	<input type="checkbox"/> Return to regular work		<input type="checkbox"/> Return with restrictions		
Referral to:	<input type="checkbox"/> Needs Additional Treatment/Follow-up Visit				
*** Please see billing information and employee care statement on the reverse of this form ***					

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Return to Work	the employee restrictions/work duties have been reviewed and employee				
<input checked="" type="checkbox"/> returned to Full Duty/No Restrictions			<input type="checkbox"/> was placed in a Modified Duty position		
<input type="checkbox"/> can not be accommodated at his time			<input type="checkbox"/> Refused Modified Duty		
<input type="checkbox"/> was sent home per medical instructions			<input type="checkbox"/> Refused Outside Treatment		
Completed by:	<u>Sterc Va. Hancock</u>		Employee Sign	(b) (6)	
Date:			Date		

[WHITE COPY - Corporate Safety Office]

[PINK COPY - GC/Site Safety]

[GREEN COPY - Employee Copy]

[YELLOW COPY - Medical Provider]

POST INCIDENT REVIEW MEETING

Date of Review meeting: 3/18/2010

Project Name:	IRS Renovation Andover
Incident Date	3/19/10
Contractor/Subcontractor	DB Contractors Inc.

Meeting Attendees:

Neil Webster	Safety Director	Columbia Construction Company
Brian Gauthier	Company Manager	DB Contractors
(b) (6)	Carpenter – injured ee	DB Contractors

Purpose of the Review

Neil Webster stated that the purpose of the meeting is to determine exactly what happened, how improvements can be made to prevent re-occurrence of the same and similar situations, and how the results can be communicated to assist in preventing re-occurrence of same or similar situations.

What happened

The injured ee was using a powder-actuated fastener tool (pistol gun-type) to fasten wood to a steel I-beam. The gun was firing intermittently, and the ee attempted to find the problem. The ee removed the fastener (nail) in the barrel, and was trying to reset the piston pin by pushing it against a piece of wood stock. The trigger also became frozen, and the ee then began pushing the end of the gun in with his left hand. Suddenly the pin released, striking the ee in the left palm.

The ee sustained an avulsion and a contusion to his left palm – medical treatment required.

Discussion of contributing factors to the incident

- Although the fastener was removed before the ee attempted to fix the tool, he did not remove the loads (shots).
- The ee acknowledged that the tool was not in very good shape, yet continued to use it.
- The situation was worsened due to the ee trying to free the jammed piston on the palm of his hand.

Improvement Plan

Brian Gauthier will contact the manufacturer's representative to conduct a training session for all the DB Contractor carpenters, and will arrange for the refresher course to be conducted annually.

DB will inventory all their tools in stock, including powder-actuated fastener tools, and repair or discard any tools that are not in perfectly working order.

How will results be communicated

Brian Gauthier will hold a DB Contractors safety meeting which will be mandatory for his employees. Power and hand tool safety will be discussed, along with safe ladder use, fall protection, and personal protective equipment. This incident will also be discussed as part of the training.

Brian will also confirm his commitment to safety and emphasize that broken or damaged tools cannot be used – he needs to be notified immediately if this condition is discovered by any of his employees.

Neil Webster, Safety Director for Columbia Construction Company, will also be in attendance at this meeting.